

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11732

## CERTIFICATE OF DEATH

11777

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Dover Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>H.</u> Middle <u>Belt</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-95</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Racing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Belt (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Benson (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction due to arteriosclerotic</u> <u>420.1</u> DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile emphysema</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>  <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>11-4</u> , 19 <u>57</u> , to <u>11-26</u> , 19 <u>57</u> . and that death occurred at <u>4:52 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>V.A. Hospital, Perry Point, Md.</u>		DATE SIGNED <u>11-27-57</u>			
PHYSICIAN'S NAME (Type) <u>S. P. IACERVA</u>		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carroll Chapel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Reisterstown, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELINE FUNERAL HOME, Reisterstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of burial place		23. Address of burial place		24. Telephone number	
25. Name of burial place		26. Address of burial place		27. Telephone number	
28. Name of burial place		29. Address of burial place		30. Telephone number	
31. Name of burial place		32. Address of burial place		33. Telephone number	
34. Name of burial place		35. Address of burial place		36. Telephone number	
37. Name of burial place		38. Address of burial place		39. Telephone number	
40. Name of burial place		41. Address of burial place		42. Telephone number	
43. Name of burial place		44. Address of burial place		45. Telephone number	
46. Name of burial place		47. Address of burial place		48. Telephone number	
49. Name of burial place		50. Address of burial place		51. Telephone number	
52. Name of burial place		53. Address of burial place		54. Telephone number	
55. Name of burial place		56. Address of burial place		57. Telephone number	
58. Name of burial place		59. Address of burial place		60. Telephone number	
61. Name of burial place		62. Address of burial place		63. Telephone number	
64. Name of burial place		65. Address of burial place		66. Telephone number	
67. Name of burial place		68. Address of burial place		69. Telephone number	
70. Name of burial place		71. Address of burial place		72. Telephone number	
73. Name of burial place		74. Address of burial place		75. Telephone number	
76. Name of burial place		77. Address of burial place		78. Telephone number	
79. Name of burial place		80. Address of burial place		81. Telephone number	
82. Name of burial place		83. Address of burial place		84. Telephone number	
85. Name of burial place		86. Address of burial place		87. Telephone number	
88. Name of burial place		89. Address of burial place		90. Telephone number	
91. Name of burial place		92. Address of burial place		93. Telephone number	
94. Name of burial place		95. Address of burial place		96. Telephone number	
97. Name of burial place		98. Address of burial place		99. Telephone number	
100. Name of burial place		101. Address of burial place		102. Telephone number	

RECEIVED  
NOV 29 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11768

## CERTIFICATE OF DEATH

Reg. Dist. No.

11778

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 4 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chesapeake City, Md.	
3. NAME OF DECEASED (Type or print) First Helen Middle Benson Last		4. DATE OF DEATH November 16, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1896
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY at Home	
13. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME James Bedwell		16. MOTHER'S MAIDEN NAME Sally LLOYD	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT Edward R. Benson		20. ADDRESS Chesapeake City, Md.	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive infection 56a.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Abdominal Incision DUE TO (c) Surgical repair of Umbilical Hernia 4 weeks 4 weeks		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 weeks	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple pulmonary emboli, Shock due to Hemorrhage		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
26. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		27. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29. (City or town) (County) (State)	
30. I certify that I attended the deceased from 14 Oct 1957 to 16 Nov 1957, that I last saw the deceased alive on 16 Nov 1957, and that death occurred at 8:45 M, from the causes and on the date stated above.			
31. ACTUAL SIGNATURE Wallace Obenshain M.D.		32. ADDRESS (Street, city or town, state) Cecilton, Md.	
33. PHYSICIAN'S NAME (Type) Wallace Obenshain M. D.		34. DATE 16 Nov 57	
35. BURIAL, CREMATION, REMOVAL (Specify) Burial		36. DATE THEREOF Nov. 18, 1957	
37. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		38. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
39. FUNERAL DIRECTOR'S SIGNATURE Donald M. Bee		40. ADDRESS Elkton, Md.	
41. REC'D BY REGISTRAR DATE Nov 18		42. REGISTRAR'S SIGNATURE J. B. Trueman	

BUREAU V.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11769

CERTIFICATE OF DEATH

Reg. Dist. No.

11779

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>Marie</b> Last <b>Biggs.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/1957</b>
9. AGE (In years last birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas W. Biggs.</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Ann Harvey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <b>Thomas W. Biggs</b>		Address <b>Elk Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>763.0</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral and bronchial asthma</b> DUE TO (b) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ----- DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1957</b> to <b>Nov. 18, 1957</b> , that I last saw the deceased alive on <b>Nov. 18, 1957</b> , and that death occurred at <b>11:20 a.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Ralph Andrews Jr.</b>		ADDRESS (Street, city or town, state) <b>233 E. Main St. Elkton, Maryland</b>	
NAME (Type) <b>S. Ralph Andrews Jr., M.D.</b>		DATE SIGNED <b>11/19/57</b>	
22a. BURIAL, CREMATION, RE-OVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walter du Bose Jr.</b>		24a. REC'D BY REGISTRAR <b>Nov 20</b>	
ADDRESS <b>Elkton Md.</b>		24b. REGISTRAR'S SIGNATURE <b>H. J. Frager</b>	

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# CERTIFICATE OF DEATH

DECEASED  
 NAME  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
 PLACE OF DEATH  
 DATE OF DEATH  
 TIME OF DEATH  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
 PLACE OF DEATH  
 DATE OF DEATH  
 TIME OF DEATH

BUREAU V. S.

NOV 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

## CERTIFICATE OF DEATH

11780

Item 7 FilmG222 11-21-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>				c. LENGTH OF STAY IN 1b <b>70 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>Brown</b> Last			4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15 1887</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Conowingo, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Berry</b>			14. MOTHER'S MAIDEN NAME <b>Jane Boddy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Oscar Tolbert</b> Address <b>Conowingo, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>3/13</b> , 19 <b>57</b> , to <b>11/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/13</b> , 19 <b>57</b> , and that death occurred at <b>4:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>569 Revolution St. Havre de Grace, Md.</b> DATE SIGNED <b>11/15/57</b>							
ACTUAL SIGNATURE <b>George T. Stansbury</b>		M.D. <b>George T. Stansbury</b>					
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zoar Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Conowingo Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>				ADDRESS <b>Residing in Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 18 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			



CERTIFICATE OF DEATH

1957

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Copied from original

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BUREAU V. S.

NOV 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11784

## CERTIFICATE OF DEATH

11781

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chestnut Grove Road</b>				d. STREET ADDRESS <b>Chestnut Grove Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Melrose</b> Last <b>Burlin</b>				4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Black Smith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Hugh Burlin</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Elizabeth Linton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-20-4901</b>		17. INFORMANT Address <b>Cyrus Burlin, Port Deposit, Md. R.F.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis -</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 24, 1957</b> to <b>Nov-16, 1957</b> , that I last saw the deceased alive on <b>Nov-16, 1957</b> , and that death occurred at <b>10 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.I. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b> DATE SIGNED <b>11/18/57</b>			
PHYSICIAN'S NAME (Type) <b>C.I. Benson, M.D.</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-19-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lucene E. Dougherty</b>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11735

CERTIFICATE OF DEATH

11782

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>				c. LENGTH OF STAY IN 1b <b>50 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>D.</b> Last <b>Calvert</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Nicholas Geisler</b>				14. MOTHER'S MAIDEN NAME <b>Anna E. Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Leroy Calvert, Charlestown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY OEDEMA -</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARDIAC OCCLUSION -</b> (c) <b>CHRONIC MYOCARDITIS -</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 day -</b> <b>5 years -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 5, 1957</b> to <b>November 9, 1957</b> , that I last saw the deceased alive on <b>November 9, 1957</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Wolbert M.D.</b> M.D. <b>200 North Union Avenue</b> <b>Nov 19, 1957</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Frank Wolbert M.D.</b>				<b>Hawode Grace Maryland</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio</b>		22d. LOCATION (City, town, or county) (State) <b>Principio furnace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-11-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>							

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11786

## CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b>				c. LENGTH OF STAY IN 1b <b>45 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Elk Mills</b> <b>x 21</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Wilmore) Wilmer Ernest Charshee</b>				4. DATE OF DEATH Month Day Year <b>11 24 1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1884</b>		9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Wilmer Ernest Charshee</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Glover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-09-8891</b>		17. INFORMANT Address <b>Joseph E. Charshee Elk Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE CORONARY THROMBOSIS</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>12 hours</b> <b>3-5 years?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>154 W. MAIN ST</b>	
				20f. (City or town) <b>ELK MILLS</b>		(County) (State)	
21. I certify that I attended the deceased from <b>11-24</b> 19 <b>57</b> , to <b>11-24</b> 19 <b>57</b> , that I last saw the deceased alive on <b>11-24</b> 19 <b>57</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>154 W. MAIN ST 11-25-57</b>							
ACTUAL SIGNATURE <b>Peter Stavrakis</b> M.D.				DATE SIGNED <b>11-25-57</b>			
PHYSICIAN'S NAME (Type) <b>PETER STAVRAKIS M.D.</b>				<b>ELK MILLS Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-27-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hayre de Grace, Harford Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>Joseph R. Grant North East, Md</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 26</b>	
				24b. REGISTRAR'S SIGNATURE <b>FR Inague</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11784  
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, R.D.</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Va</b> b. COUNTY <b>Patric</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woolwine</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Homer</b> First <b>Chester</b> Middle <b>Clark</b> Last				4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-15-1913</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Constuction</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jack Clark</b>				14. MOTHER'S MAIDEN NAME <b>Lottie M. Boyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>230-20-5876</b>		17. INFORMANT Address <b>William Clark, Woolwine Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary</b> <b>2</b> DUE TO <b>Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Alcoholism</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>11-7-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clark Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ferrum Franklin Co. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Lee A. Patterson &amp; Son Perryville Md</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	
DATE <b>11-8-57</b>							

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11788

## CERTIFICATE OF DEATH

11785

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write city, town and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Box # 113</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES A. COLLINS</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-90</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Perryman, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Collins (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lee (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, name or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217 05 2301</b>	
17. INFORMANT <b>HOSPITAL RECORDS, VA HOSPITAL, PERRY POINT, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Glomerulonephritis, Chronic</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>Over 5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-4-57</b> , 19 <b>57</b> to <b>11-15-</b> , 19 <b>57</b> , and that death occurred at <b>6:35P</b> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE <b>NOV 21 1957</b>	
ACTUAL SIGNATURE <b>S. P. Lacerva</b> M.D.			
PHYSICIAN'S NAME (Type) <b>S.P. LACERVA, M.D., Director Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>	
ADDRESS <b>ABERDEEN, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>James Dougherty</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11770

## CERTIFICATE OF DEATH

11786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oliver Wesley Collins		4. DATE OF DEATH November 14 1957	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1902 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	11. BIRTHPLACE (State or foreign country) Delaware
13. FATHER'S NAME Oliver Henry Collins		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
14. MOTHER'S MAIDEN NAME Mary A. Hess		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-05-4665		17. INFORMANT Address Lewis A. Collins Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 10, 1957, to Nov 15, 1957, that I last saw the deceased alive on Dec 15, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry D. Davis M.D.		ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED 11/16/57	
PHYSICIAN'S NAME (Type) HENRY D. DAVIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-17-1957	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) R. D. Chesapeake CITY, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Lee		24a. REC'D BY REGISTRAR DATE Nov 18	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE FR Frazier	

RECEIVED

NOV 19 1957

BUREAU V.

11789

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>9yrs.9mo.16days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>H.</b> Last <b>COOPER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Day &amp; 1897 Month unknown</b>	
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW I</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, left lower lobe</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, mild - unknown</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 17, 1948</b> , to <b>November 18, 1957</b> , and that death occurred at <b>10:20a M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. P. LACERVA</b>				ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-19-57</b>			
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Harry</b> ADDRESS <b>de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lucas E. Wang</b>	

STANDARD A. 1

NOV 22 1957

NOV 22 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11771 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11788  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark P.D. 2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital D.O.A.</b>				d. STREET ADDRESS <b>Celn Farm</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Rulon</b> Last <b>Dare</b>				4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-25-1929</b>		9. AGE (In years last birthday) <b>28</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>13</b> Hours <b>13</b> Min.	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fiber Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New Brunswick, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C. Rulon Dare</b>				14. MOTHER'S MAIDEN NAME <b>Mary Richardson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>150-20-7136</b>		17. INFORMANT <b>C. Rulon Dare</b> Address <b>Newark, Del. P.D. 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Newark</b>		(County) <b>Del.</b>	(State) <b>Del.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-14-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/16/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Friends Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenwich N.J.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walter du Bose Jr.</b>				ADDRESS <b>Ellicott 4th</b>		24a. REC'D BY REGISTRAR <b>DATE 11/17</b>	24b. REGISTRAR'S SIGNATURE <b>FR Bagn</b>

RECEIVED

NOV 19 1957

BUREAU A

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11790

## CERTIFICATE OF DEATH

1178990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>H.</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID MALONE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WHITFIELD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO	
17. INFORMANT <u>WILLIAM DAVIS,</u>		Address <u>CECILTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Blindness complete.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 19, 1957</u> to <u>Nov 16, 1957</u> that I last saw the deceased alive on <u>16 Nov</u> , 1957, and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>CECILTON, MD.</u>		<u>19 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>		<u>CECILTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11/19/57</u>	<u>CECILTON COL. CEM.</u>	<u>CECILTON MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Sallows, Millington, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mrs Ralph H. Rees</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

NOV 1964

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11772

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11720  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 178 Water St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle B Last Dean				4. DATE OF DEATH Month 11 Day 6 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1895		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry O. Dean				14. MOTHER'S MAIDEN NAME Martha Holt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Ralph H. Dean, 520 North St. Elkton. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 11-7-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-57		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Cecil Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Henry Jappin				24a. REC'D BY REGISTRAR DATE Nov 9		24b. REGISTRAR'S SIGNATURE H. H. Jappin	

MEDICAL CERTIFICATION

BUREAU V. S.

NOV 12 1957

RECEIVED

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Will 2222 11-18-57 et

11791

## CERTIFICATE OF DEATH

11791

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Orange</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>177 S. Burnett</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>H.</b> Last <b>DIXON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-98</b>
9. AGE (In years lost birthday) yrs. <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
13. FATHER'S NAME <b>John Dixon</b>		14. MOTHER'S MAIDEN NAME <b>Kate Grimm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tuberculosis, pulmonary</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 6, 19 56</b> , to <b>November 4, 19 57</b> , and that death occurred on <b>10:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D.		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-6-57</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-6-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>County</b>		22d. LOCATION (City, town, or county) (State) <b>Bloomfield, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Harve de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-8-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Inene E. Dougherty</b>			

BUREAU V. S.

NOV 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 333. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11792

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11792

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cecil St.</u>				d. STREET ADDRESS <u>Cecil St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Keith</u> Middle <u>Jerome</u> Last <u>Garnet</u>				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1957</u>		9. AGE (In years last birthday) yrs. <u>4</u> Months <u>17</u> Days <u>17</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Garnet</u>				14. MOTHER'S MAIDEN NAME <u>Betty Albert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mrs. Betty Garnet, Chesapeake City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide Poisoning</u> <u>890.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome by smoke and fumes from coal Oil stove</u>					
20c. TIME OF INJURY Month, Day, Year <u>1</u> o. m. <u>11-18,</u> 57 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Chesapeake City Cecil Md.</u>		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald G. Zee</u>				ADDRESS <u>ELKTON, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 19</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. Ralph J. Shies</u>		DATE SIGNED <u>11-18-57</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11793

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11793

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor Heights		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xx Mznaz Port Deposit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Naval Hospital.				d. STREET ADDRESS Manor Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Jane Grace				4. DATE OF DEATH Month Day Year 11 26 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-19-1901	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Samuel McWilliams				14. MOTHER'S MAIDEN NAME Delia Stiffler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT Address John Gilbert Hager, Santiago. Cal.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Long Standing Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 11-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Mixa, Missouri		22d. LOCATION (City, town, or county) (State) Mixa Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Keea Patterson				ADDRESS Perryville, Md.		24c. REC'D BY REGISTRAR DATE 11/29/57	
				24b. REGISTRAR'S SIGNATURE James E. Langherty			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11794

## CERTIFICATE OF DEATH

11794

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>35 E. Stewart Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>F.</b> Last <b>HAEGELE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-31-91</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	11. IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b> (b) <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 8, 1922</b> , to <b>November 8, 1957</b> , and that death occurred on <b>10:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-14-57</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>11-13-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Harro, de Grace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Gougherty</b>	

BUREAU V. S.

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11795

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>7yrs.8mo.5days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>5901 Bellona Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>F.</b> Last <b>HAWLEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willis Chatman Hawley</b>		14. MOTHER'S MAIDEN NAME <b>Anna W. Geisendorfer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-07-2315</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Paralysis, agitans (Parkinson's disease)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3-5 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>March 24</b> , 19 <b>50</b> , to <b>November 29</b> , 19 <b>57</b> , and that death occurred at <b>12:30a</b> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		DATE SIGNED <b>11-29-57</b>
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>11-29-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>
22d. LOCATION (City, town, or county) (State) <b>Lancaster County, Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peppington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>
24a. REC'D BY REGISTRAR <b>11-29-57</b>		24b. REGISTRAR'S SIGNATURE <b>Irma E. Daugherty</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 2 1957

BUREAU V. S.

11773

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u> 14-2-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE E. HICKS</u>		4. DATE OF DEATH Month Day Year <u>Nov. 28 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1882</u> 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLACKSMITH</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>JAMES R. HICKS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE CHRISTFIELD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-12-1758</u>	
		17. INFORMANT Address <u>MRS. ETTA HICKS, GALENA, MD.</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u> DUE TO (b) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u>  <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January, 1957</u> to <u>28 Nov</u> , 1957, that I last saw the deceased alive on <u>28 Nov</u> , 1957, and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u> DATE SIGNED <u>30 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>		<u>Cecilton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>M.E. CHURCH YARD</u>	22d. LOCATION (City, town, or county) (State) <u>GALENA, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Fryer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 19

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11774

CERTIFICATE OF DEATH

11797

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
c. LENGTH OF STAY IN 1b 2 Days				d. STREET ADDRESS 414 North St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Oscar Pugh Humes				4. DATE OF DEATH Month Day Year 11 24 19 57			
5. SEX	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16th 1902	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Aerial Products		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Humes				14. MOTHER'S MAIDEN NAME Margaret Pugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 161-07-0607		17. INFORMANT Mrs Chas L. Loward, Elkton, Maryland			
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1. Influenza-11/5-11/11/57; 2. diabetes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 24, 1957, to Nov. 24, 1957, that I last saw the deceased alive on Nov. 24, 1957, and that death occurred at 5:15a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		M.D. 233 E. Main Street		11/24/57		DATE SIGNED	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/57		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter Aubrey Jr.		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 11/27		24b. REGISTRAR'S SIGNATURE F. F. Frazier	

BUREAU V. S.

DEC 1 1917

RECEIVED

11796

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Rising Sun</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Margaret Keim</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johnstown, Pa</u>	
11. FATHER'S NAME <u>Frederick Steiner</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frederick Steiner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wilhelm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mildred K. Balling</u>		Address <u>Rising Sun, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 1951</u> , to <u>11/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>57</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>		DATE SIGNED <u>11/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trilphian Manor Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 12 57</u>		24b. REGISTRAR'S SIGNATURE <u>Pauline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 13 1957

BUREAU V. S.

11775

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hacks Point X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. D. Earleville, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Atkins KIRK				4. DATE OF DEATH Month Day Year Nov. 4 1957			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1887		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender		10b. KIND OF BUSINESS OR INDUSTRY State Rd. Com.		11. BIRTHPLACE (State or foreign country) Bethel Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Ruley Kirk				14. MOTHER'S MAIDEN NAME Margaret Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-09-9985		17. INFORMANT Mrs. Kathryn Kirk, Earleville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 10, 1950, to Nov. 4, 1957, that I last saw the deceased alive on Nov 4, 1957, and that death occurred at 2:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/4/57							
ACTUAL SIGNATURE [Signature] M.D.				CHESA PEAKE CITY MD			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin ADDRESS Elkton Md.				24a. REC'D BY REGISTRAR DATE Nov 6		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 7 1957

RECEIVED

## CERTIFICATE OF DEATH

11800

Reg. Dist. No. 96

11797

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>35yrs. lmo. 28days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1619 - 6th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>V.</b> Last <b>LESIRE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-87</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Belgium</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Lesire</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> <b>581-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver Laennec's</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 8, 1922</b> , to <b>November 5, 1957</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. S. ELLS,</b>				M.D. <b>V.A. Hospital, Perry Point, Md.</b>			
PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D.</b>				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11-12-57</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Dougherty</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11798

## CERTIFICATE OF DEATH

Reg. Dist. No.

11801

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>35 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>G.</b> Last <b>Lort</b>				4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 12, 1887</b>	
9. AGE (In years last birthday) yrs <b>70</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>15</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>6-----</b>		11. BIRTHPLACE (State or foreign country) <b>Port Deposit Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Francis H. Gerhauser</b>				14. MOTHER'S MAIDEN NAME <b>Ida Vermont Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles G. Lort Lancaster, Penna</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>57</b> , to <b>28 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>28 Nov</b> , 19 <b>57</b> , and that death occurred at <b>12:45 P.</b> M, from the causes and on the date stated above.							
DEATH SIGNATURE <b>Klaus H. Hubner</b> M.D.				ADDRESS (Street, city or town, state) <b>No. 11 E. 4 Rd</b> DATE SIGNED <b>29 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>Klaus H. Hubner M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11-30-57</b>		24b. REGISTRAR'S SIGNATURE <b>Joseph E. Rothermel</b>	

BUREAU V. S.

NOV 8 1917

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NOV 8 1917

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11802

Reg. Dist. No.

Items 3 & 13  
Film G-222 11/21/57

Item 9 Film G-222 11-18-57 et

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East R.D.</b>		c. LENGTH OF STAY IN 1b <b>Blkmills</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Blkmills</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Susquehannah Flats</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Andrew Anderson</b>		First <b>George</b>		Middle <b>Andrew</b>		Last <b>Mann, Jr.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>1957</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-5-1930</b>		9. AGE (In years last birthday) <b>27 1/2</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov. Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Blkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Anderson Mann, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret McCann</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Korean 219-28-3438</b>		17. INFORMANT <b>Geor A. Mann, Blkmills, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Blkton</b>		(County) <b>Maryland</b>		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
21. ACTUAL SIGNATURE <b>R. C. Dodson</b>		EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-8-57</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Cem.</b>		22d. LOCATION (City, town, or county) <b>Blkton</b>		(State) <b>Maryland</b>		24a. REC'D BY REGISTRAR <b>Joseph R. Grant</b>		24b. REGISTRAR'S SIGNATURE <b>Joseph R. Grant</b>		24c. DATE <b>11-11-57</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

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NOV 13 1957

RECEIVED

11800

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 306 F. Street, N. W.	
3. NAME OF DECEASED (Type or print) First JACOB I Middle J. Last MARAN		4. DATE OF DEATH Month November Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-89
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Photostat - Govt.	
11. BIRTHPLACE (State or foreign country) Turkey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Maran		14. MOTHER'S MAIDEN NAME Hazel ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 578-46-8391	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation due to foreign substance (metamucil) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralysis agitans, severe (clinical) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe - unknown			INTERVAL BETWEEN ONSET AND DEATH 20 minutes unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15, 1957, to November 29, 1957, and that death occurred at 10:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 12-4-57 ACTUAL SIGNATURE S. F. LACERVA PHYSICIAN'S NAME (Type) Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 12-4-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Lucina E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

RECORDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11804

## 11801 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>Maryland</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>			d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Marquis</u>			4. DATE OF DEATH Month Day Year <u>11/30/57</u> <u>19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1872</u>	9. AGE (In years lost birthday) yrs <u>85</u>	IF UNDER 1 YEAR: Months Days Hours Min. <u>—</u> <u>—</u> <u>—</u> <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. FATHER'S NAME <u>Wm. Marquis</u>			14. MOTHER'S MAIDEN NAME <u>Bella Price</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Mrs. Alice S. Marquis</u> Address: <u>Charlestown Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE (PULMONARY EMBOLISM)</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>CIRRHOSIS OF LIVER</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>57</u> , to <u>11/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>57</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 N. Union Ave</u> DATE SIGNED <u>12-2-57</u>					
ACTUAL SIGNATURE <u>J. Randall</u> M.D. <u>200 N. Union Ave</u> <u>12-2-57</u>					
PHYSICIAN'S NAME (Type) <u>J. Randall</u> <u>Have De Grace, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>12/3/57</u>	<u>Charlestown</u>	<u>Charlestown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forrest J. H. H. H. H. H.</u>		ADDRESS <u>—</u>	24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>A. S. Lewis M.D.</u>	

BUREAU V. S.

DEC 6 1957

RECEIVED  
FBI - NEW YORK

## 11802 CERTIFICATE OF DEATH

11805

Reg. Dist. No. 90

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HACKS POINT Cecilville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HACKS POINT Cecilville</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>H</u> Last <u>MAY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>tenant-farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Joseph May</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>318-14-674</u>			
17. INFORMANT <u>Clara R May Cecilville MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>multiple pulmonary emboli, 2 recent Cerebrovascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>  <u>years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>21 Nov.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Nov</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Churnish</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>25 NOV 57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 26 1957</u>		<u>Cecilton Lin</u>		<u>Cecilton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Shaw</u> ADDRESS <u>Millington Md</u>				24. REC'D BY REGISTRAR <u>Mr. Ralph R. ...</u> DATE <u>107</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 27 1967

BUREAU V. E.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11806

11803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo, R.D.</b>			c. LENGTH OF STAY IN 1b <b>10 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>G</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-17-1890</b>		9. AGE (in years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b> Hours <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Thaxton, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington Miller</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Myrtle Miller, Conowingo, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>11-22-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stags Creek Cem</b>		22d. LOCATION (City, town, or county) (State) <b>West Jefferson N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson Rising Sun, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 25 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

11804

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES A. NICK		4. DATE OF DEATH Month Day Year November 5 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1899
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Oysterman	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Nick		14. MOTHER'S MAIDEN NAME Annie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-16-4120	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis of right lung, far advanced, active DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis of Iliofemoral veins - 5 days 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 1957, to November 5, 1957, and that death occurred at 2:32 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md. 11-6-57 PHYSICIAN'S NAME (Type) Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-6-57	
22c. NAME OF CEMETERY OR CREMATORY St. Matthews' Cemetery		22d. LOCATION (City, town, or county) (State) Shady Side, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hibbs Funeral Home, Annapolis, Md.		24. REC'D BY REGISTRAR DATE 10/7/57	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV. 8 1957

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11808

11805

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 4714n Kernwood Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Willard Clifton Pierce, Sr.				4. DATE OF DEATH Month Day Year 11 18 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1902	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. Executive		10b. KIND OF BUSINESS OR INDUSTRY Auto Sales		11. BIRTHPLACE (State or foreign country) Auburn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME P Arthur E. Pierce				14. MOTHER'S MAIDEN NAME Margaret Cramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.2		17. INFORMANT Address 1424 Dartmouth		18. WILLARD C. Pierce, Jr. Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7~8x DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO (b)</p> <p>DUE TO (c)</p> </div> <div style="width: 65%;"> <p>Crushed Chest and Internal Injuries</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from Chesapeake City Bridge Md					
20c. TIME OF INJURY Month, Day, Year 11 18 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake City Chesapeake City Cecil		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11-19-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Wood lawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald H. De</i>				ADDRESS Elkton, Md		24a. REG'D BY REGISTRAR DATE Nov 19	
				24b. REGISTRAR'S SIGNATURE <i>Mr. Ralph N. Hays</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 21 1

RECEIVED

11776

CERTIFICATE OF DEATH

11810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jody Middle Lynn Last Reynolds		4. DATE OF DEATH Nov 10 1957	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1957
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Halus Reynolds Jr.		14. MOTHER'S MAIDEN NAME Pauline Peterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Halus Reynolds Jr.		138 Hollingsworth Lane Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 11/10 DUE TO Prolonged labor and malposition of baby Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) (Baby lived 65 minutes after delivery) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1957, to Nov. 10, 1957, that I last saw the deceased alive on Nov. 10, 1957, and that death occurred at 11:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Ralph Andrews, Jr.		DATE SIGNED 11/10/57	
PHYSICIAN'S NAME (Type) B. Ralph Andrews, Jr., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-1957	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo. Pk.		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR DATE Nov 12	
ADDRESS Elkton Md.		24b. REGISTRAR'S SIGNATURE J. H. S. Sager	

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BUREAU V. S.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-3-57 et

11777

CERTIFICATE OF DEATH

11811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2-weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Reynolds</u> Last <u>Reynolds</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1882</u>	9. AGE (In years last birthday) <u>75 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Anna Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-360003</u>		17. INFORMANT Address <u>Mrs. Rebecca Reynolds Rising Sun Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>491X</u> DUE TO <u>Senility.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BENIGN PROSTATIC HYPERTROPHY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>10/9</u> , 19 <u>57</u> , to <u>11/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/23</u> , 19 <u>57</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Fischer</u>				ADDRESS (Street, city or town, state) <u>162 W MAIN ST., Rising Sun Md.</u>			
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>				DATE SIGNED <u>11/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Co. Colonus Md.</u>		22d. LOCATION (City, town, or county) (State) <u>  </u> <u>  </u> <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Tyson</u>				ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. R. Shyers</u>			



NOV 27 1957

BUREAU

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11812

## CERTIFICATE OF DEATH

Reg. Dist. No.

11778

Item 1, See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>MD</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Elkton</b>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Port Deposit</b>	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>14 hnd</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Riffey</b>		4. DATE OF DEATH Month Day Year <b>11 26 19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-57</b>
9a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Infant</b>		9b. AGE [In years last birthday] <b>14</b>	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elkton, Md.</b>	
11. BIRTHPLACE [State or foreign country] <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Blaine Perry</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jane Riffey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Nancy J. Riffey Port Deposit, Md.</b>	
17. INFORMANT <b>Nancy J. Riffey Port Deposit, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atlectasis left lung.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-26-57</b> , 19 <b>57</b> , to <b>11-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-26</b> , 19 <b>57</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. C. Dodson</b>		DATE SIGNED <b>11-27-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/4/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Colora md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed</b>		24a. REC'D BY REGISTRAR <b>12/1/57</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Fryer</b>	

ESTABLISHED V. S.

DEC 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11813

Reg. Dist. No. 90

11806

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Chesapeake City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin Wilson First Middle Last Ross				4. DATE OF DEATH Month 11 Day 20 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 27-1912.		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY all kinds of work		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Ross				14. MOTHER'S MAIDEN NAME Florence P. Forsythe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-30-2696		17. INFORMANT Address Eleanor Inslo. Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung himself with a rope over a beam					
20c. TIME OF INJURY Month, Day, Year Hour 11 p.m. 11 20 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Chesapeake City Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-57		22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Chesapeake City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Lewis, Millington, Md.				24a. REC'D BY REGISTRAR NOV 25 1957		24b. REGISTRAR'S SIGNATURE Mrs. Ralph Ross	

BUREAU V. S.

NOV - 1 1977

RECEIVED

11779

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
		d. STREET ADDRESS <u>Main St.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Naomi</u> Last <u>Rouse</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1916</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR: Months <u>41</u> Days <u>41</u> Hours <u>41</u> Min. <u>41</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake City, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carter</u>		14. MOTHER'S MAIDEN NAME <u>Ida Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>Chas Rouse Chesapeake City, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular disease</u> DUE TO <u>yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 31, 1957</u> to <u>Nov 2, 1957</u> , that I last saw the deceased alive on <u>Nov 2, 1957</u> , and that death occurred at <u>4:10</u> P. M. from the causes and on the date stated above.			
SIGNATURE <u>Wallace Oberbain</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Oberbain</u>		DATE SIGNED <u>3 Nov 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bohemian Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Steppin</u>		ADDRESS <u>Cecilton, Md</u>	
24a. REC'D BY REGISTRAR <u>Nov 6</u>		24b. REGISTRAR'S SIGNATURE <u>HR Brager</u>	

BUREAU V. S.

1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

11807

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>4 Mon. 6Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>333 N. Charles Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Larry</b> Middle <b>E.</b> Last <b>Shaffer</b>		4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-87</b>
9. AGE (In years birth day) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (Cash Registers)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Laura Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-07-4598</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage non-traumatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>7-12-</b> , 19 <b>57</b> to <b>11-17</b> , 19 <b>57</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. <b>V.A. Hospital, Perry Point, Md. 11-18-57</b> PHYSICIAN'S NAME (Type) <b>S.P. LACERVA, M.D., Director Professional Services, VA Hospital, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>11-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart &amp; Mowen Fun.Home, 108 W. North Ave. Baltimore</b>		24. REC'D BY REGISTRAR <b>19 NOV 19 1957</b>	
24a. REGISTRAR'S SIGNATURE <i>Gene Dougherty</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RÉCEIVED

NOV 19 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11808

## CERTIFICATE OF DEATH

11816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Confluence</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Page Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL E. SMITH</b>		4. DATE OF DEATH Month Day Year <b>11 24 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-21-11</b>
9. AGE (In years last birthday) yrs <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Harry E. Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Matthews</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b> (If yes, give year or dates of service) <b>WWII</b>	
16. SOCIAL SECURITY NO. <b>192-09-4223</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peritonitis, due to Extravasated contents of Viscera</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 To 5 Days</b> <b>10 To 12 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <b>7 19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-31-45</b> , 19____, to <b>11-24-</b> , 19 <b>57</b> . and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>11-24-57</b> ACTUAL SIGNATURE <b>E. S. Ellis</b> M.D. PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D., Acting Director, Professional Services, VAH, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-24-57 Burial</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Addison Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Addison, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>11-29-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Irene E. Dougherty</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7-18-14

BUREAU V. S.

NOV 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11809

## CERTIFICATE OF DEATH

Reg. Dist. No.

11817  
96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 222</b>		d. STREET ADDRESS <b>Route 222</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1880</b>
9. AGE (In years, birth day, yrs.) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stove Foundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Louisa Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>216-07-2052</b>	
17. INFORMANT <b>Mrs Carrie Smith, Perryville, Md. Rural</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chromophilic</b> <b>5230</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September, 1942</b> to <b>Nov. 13, 1957</b> , that I last saw the deceased alive on <b>Nov. 13, 1957</b> , and that death occurred at <b>12:34 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. I. Benson</b>		ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. I. Benson M.D.</b>		DATE SIGNED <b>11/15/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-16-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>11-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>Lucene E. Dougherty</b>	

BUREAU V. E.

NOV 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11819

Reg. Dist. No.

11780

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>0</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital, D.O.A.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East, R.D.</u> d. STREET ADDRESS <u>Princess Ann Trailer Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Walter Leo Taylor</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>11 9 1957</u>													
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-12-1902</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Checker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Air port</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Rock M. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>John Irvin Taylor</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ruth Hanna Foster</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>232-12-7163</u>		<b>17. INFORMANT</b> Address <u>Mrs. Lily North East Md</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME</b> (Type) <u>R.C. Dodson</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-10-57</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Nov 12/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopewell Cem</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Pising Sun, Md.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Earl Tyson</u>				<b>ADDRESS</b> <u>Pising Sun, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>11-13-1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>F. K. Shyer</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 14 1911

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11820

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

11810

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Washington, DC</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 year-4days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>114 Seneca Dr. SE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VA Hospital, Perry Point, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Aage (NMI) Westergaard</b>		4. DATE OF DEATH Month Day Year <b>November 4 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-73</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anders Westergaard</b>		14. MOTHER'S MAIDEN NAME <b>Hedvig Nielsen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Not ascertainable</b>	
17. INFORMANT <b>VAH, Perry Point, Md. (Hospital Records)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis right, organism unknown, due to obstruction</b> DUE TO (b) <b>Papillary carcinoma of the bladder</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-30-</b> 19 <b>56</b> to <b>11-4-57</b> , 19 <b>57</b> and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Perry Point, Md. 11-5-57</b>			
ACTUAL SIGNATURE <b>E. S. Ellis</b>		M.D. <b>VA Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>E.S. ELLIS, M.D.</b>		Actg. Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>11-5-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Remington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-5-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Irene E. Dougherty</b>			

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

118:1

## CERTIFICATE OF DEATH

Reg. Dist. No.

91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. LENGTH OF STAY IN 1b 2 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgans Nursing Home				d. STREET ADDRESS McCool Apts North St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Bertha L. White				4. DATE OF DEATH Month Day Year 11 19 19 57			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 1 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk				10b. KIND OF BUSINESS OR INDUSTRY Kennard Pyle Co			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Clinton Johnson White				14. MOTHER'S MAIDEN NAME Martha Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Tobe Rudolph 515 North St Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis. DUE TO (b) Cerebral Arteriosclerosis. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed fast for years. Senility.							
INTERVAL BETWEEN ONSET AND DEATH 3 days.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 15 Nov. 19 57 to 19 Nov. 19 57, that I last saw the deceased alive on 19 Nov. 19 57, and that death occurred at 1 14 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Oltenshain M.D.				ADDRESS (Street, city or town, state) Cecilton Md. DATE SIGNED 20 Nov 57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Onevell Cemetery		22d. LOCATION (City, town, or county) (State) Onevell, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REQ'D BY REGISTRAR DATE Nov 23, 1957		24b. REGISTRAR'S SIGNATURE Mrs. Ralph Reep	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11781

CERTIFICATE OF DEATH

11821

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>UNION, ELKTON, MD</u>				d. STREET ADDRESS <u>Roll Mill Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>Grafton</u> Last <u>Wharton</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.9.27</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FIRE BRICK</u>		11. BIRTHPLACE (State or foreign country) <u>North East, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Harry Wharton</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Bryan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-20-5873</u>				17. INFORMANT <u>Mrs. Carrie Wharton North East Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>RHEUMATIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u> <u>5 days</u> <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible SUBACUTE BACTERIAL ENDOCARDITIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11:4</u> <u>1957</u> to <u>11:10</u> <u>1957</u> , that I last saw the deceased alive on <u>11:10</u> <u>1957</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>Nov. 10 57</u>							
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.				PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-13-1957</u>				22b. DATE THEREOF <u>Methodist</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>North East Cecil Co., Md</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Shant</u> ADDRESS <u>North East Md</u>				24a. REC'D BY REGISTRAR <u>Nov 13</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Frazer</u>	

BUREAU V. S.

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11812 CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>PATTERSON</b> Last <b>WYRE Sr.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-5-1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mixer Triumph Explosives</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fireworks</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Wyre</b>		14. MOTHER'S MAIDEN NAME <b>Anna Alexander</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-4645</b>	
17. INFORMANT <b>Mrs Madeline Myre</b>		Address <b>North East, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> <b>Uremia</b> DUE TO <b>Generalized cardiac hypertrophy and dilatation with passive congestion of lungs, liver, kidneys.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Chronic bronchial asthma and pulmonary emphysema</b> (c) <b>14 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric Ulcer - pre-pyloric</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>5 a. m.</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 19 <b>46</b> , to <b>2 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1 Nov</b> , 19 <b>57</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Klaus H. Huebner</b>		DATE SIGNED <b>3 Nov 57</b>	
PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner M.D.</b>		ADDRESS (Street, city or town, state) <b>North East, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-5-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R Grant</b>		24a. REC'D BY REGISTRAR <b>DATE 11-6-57</b>	
ADDRESS <b>North East, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Savaly, E. Rothermel</b>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824

11813

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Newark, Del.</b>				c. LENGTH OF STAY IN 1b <b>Rural-Newark, Del. x/</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Newark, 405 Jackson Hall School Rd. Del.</b>				d. STREET ADDRESS <b>Newark, Delaware 405 Jackson Hall School Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Wildman</b> Last <b>Zebley</b>				4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Elwood Zebley</b>				14. MOTHER'S MAIDEN NAME <b>Georgeanna Wildman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>221-10-7949A</b>		17. INFORMANT <b>405 Jackson Hall School Rd. Mrs. Anna B. Zebley Newark, Delaware</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumothorax with mediastinal shift - about 2 yrs duration</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3</b> , 19 <b>53</b> to <b>Nov. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 10</b> , 19 <b>57</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>				ADDRESS (Street, city or town, state) <b>233 E. Main Street</b>		DATE SIGNED <b>11/11/57</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>				<b>Elkton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Head of Christiansa</b>		22d. LOCATION (City, town, or county) (State) <b>Newark, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.T. Jones</b>				ADDRESS <b>Newark, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>11/16/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>FR Trauger</b>			

# CERTIFICATE OF DEATH

Form No. 10

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

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